PRINTED: 07/28/2015

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE MB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	TION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495342	B. WING _		C	
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE  113 BATTLE ROAD  YORKTOWN, VA 23692	07/16/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 000 F 157 SS≈D	An unannounced Medicare/Medicaid standard survey was conducted on 7/14/2015 through 7/16/2015. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow.  The census in this 80 certified bed facility was 72 at the time of the survey. The survey sample consisted of 14 current resident reviews (Residents 1-13 and 19) and 5 closed record reviews (Residents 14-18). One complaint was investigated during the survey.		F 000	submitted as evidence of alleged compliance. The submission is not admission that the deficiencies exist or that we are in agreement with the lt is an affirmation that corrections that areas cited have been made and the facility is in compliance with participation requirements.	an sted em. o the sat	
	consult with the residence, known, notify the residence or an interested farm accident involving the injury and has the pointervention; a signification in healt status in either life the clinical complications significantly (i.e., a nexisting form of treat consequences, or to treatment); or a decist the resident from the §483.12(a).  The facility must also and, if known, the residence or an interest of the resident from the same of the resident from the same of the facility must also and, if known, the resident from the resident from the facility must also and, if known, the resident from the same of the facility must also and, if known, the resident from the same of the facility must also and, if known, the resident from the same of the facility must also and, if known, the resident from the same of the facility must also and, if known, the resident from the same of the facility must also and, if known, the resident from the same of the facility must also and the facility must	commence a new form of sion to transfer or discharge facility as specified in promptly notify the resident sident's legal representative		1. Resident #15 no longer resides at the facility. The medical record for resident #11 was reviewed for the p 30 days to ensure that the physician has been notified of any change in condition in a timely manner.  2. The Director of Nursing/Designee has reviewed all incidents for the pa 30 days to ensure the responsible phas been notified in a timely manner. The Director of Nursing/Designee has reviewed the medication administrative records for all current resident from past 30 days to ensure the physician has been notified of any medications that have not been administered due the resident's refusal.	e 8/27/15 & est ongoing arty r. eas tion the n	
	and, if known, the res	sident's legal representative nember when there is a		ino residenta reiusal.		

LABORATOR DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

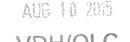
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for hursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: OMY111

Facility ID: VA0282

RECE Vi continuation sheet Page 1 of 34

(X6) DATE



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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FO OMB I	RM APPROVE NO. 0938-039	
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	RRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3)	(X3) DATE SURVEY COMPLETED	
		495342	B. WING		hammer and succession of the s	С	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		07/16/2015	
VABVA	**************************************	might gifte many		113 BATTLE ROAD	ODE		
IORN	ONVALESCENT CEN	IEK	ALL PROPERTY.	YORKTOWN, VA 23692			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETION DATE	
F 157	Continued From pa	ne 1	<b>r</b> 47	The American Division of the Control	NAMES AND ASSESSMENT OF THE PROPERTY OF THE PR	mes (agriculos de la qui a Cial-em-et verse verse ciù adocent la comi - applicate determina comp	
	change in room or r specified in §483.1 resident rights unde regulations as spec this section.  The facility must red	roommate assignment as 5(e)(2); or a change in or Federal or State law or ified in paragraph (b)(1) of cord and periodically update	F 18	The Assistant Director of Nursing/Designee will be res for ensuring the responsible been notified of incidents in a manner. The charge nurse of will be responsible for ensuring physician is notified if resider refusing medications.	party has a timely n each shift ng that the		
the address and phone number of the resident's legal representative or interested family member.			RN/LPNs will be reeducate     Nursing Education and Traini	ing	8/27/15 & ongoing		
	by: Based on staff inter review, clinical recor a complaint investiga for 2 residents (Resi	T is not met as evidenced view, facility documentation d review, and in the course of ation, the facility staff failed dent #15 and		Coordinator on "Responsible Physician Notification". The ir includes but is not limited to to notification of the responsible physician regarding changes condition and incidents.	nservice imely party and	3 - 3	
	#11) of 19 residents	in the survey sample, to e party and the physician in a		<ol> <li>The Director of Nursing/De monitor 100% of incident repo weeks to ensure that the resp</li> </ol>	orts for six onsible	8/27/15 & ongoing	
	notify the Responsible	, the facility staff failed to le Party (RP) of a resident to and a fall in a timely manner.		party has been notified of incide Director of Nursing/Designee monitor 20% of medication administration records for 6 weeks about the physician by the physicia	will eeks to		
	physician ordered Mi constipation) in June 2015. Resident #11'	was not being administered		ensure the physician has beer of medications that have not be administered due to resident range from the Any trends or variances will be reviewed and addressed. The will be reported to the CQI contains the results of the contains	een efusal. e findings		

The findings included:

1. Resident #15 was admitted to the facility on 10/7/14 with the diagnoses of, but not limited to, Alzheimer's Dementia, encephalopathy and hypertension. Resident #15 was discharged to

Facility ID: VA0282

on at least a quarterly basis.

If continuation sheet Page 2 of 34

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OMY111

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORI	M APPROVEI <u>D. 0938-039</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION MINISTED. I		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495342	B. WING	š		n-	C 7/ <b>16/201</b> 5	
NAME OF	PROVIDER OR SUPPLIER		L.	ε	STREET ADDRESS, CITY, STATE, ZIP CODE	_ <u></u>	7710/2013	
YORK C	ONVALESCENT CENT	TER		l	13 BATTLE ROAD YORKTOWN, VA 23692			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTION (CROSS-REFERENCE)	DBE	(X5) COMPLETION DATE	
	holding her chest. Ethe facility during the review was conduct. The most recent Min an initial assessmen Reference Date of 1 Resident #15 with se required set up only except eating which physical assistance; towards others and toward others; wand intruded on the private Resident #15 was contracted to the contraction of the private Resident #15 was contracted to the contraction of the private Resident #15 was contracted to the private Resident #15 was contracted to the contracted prior to the contracted private Resident #15 on the private Resident R	6/14 due to shaking, igh blood pressure and Being Resident #15 was not in a survey a closed record ed.  Inimum Data Set (MDS) was not with an Assessment 0/14/14. The MDS coded evere cognitive impairment; for all activities of daily living Resident #15 required no physical behaviors directed other behaviors not directed ering daily that significantly acy or activities of others. Each with a fall without injury of admission to the facility.  I.m., Resident #15's clinical and the complete head to toe are with no evidence of injury, and noted. MD (medical models) and the control of 10/25/14 at dent found on floor by aide		157				
1	on hands and knees	dent found on floor by aide no injury or pain noted at doctor) made aware vitals						

normal left message for rp (responsible party) to call back." There were no post fall assessments



CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 07/28/201 RM APPROVE O: 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) D	ATE SURVEY OMPLETED
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YORK C	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 113 BATTLE ROAD YORKTOWN, VA 23692	DDE 0	7/16/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD RE	(X5) COMPLETION DATE
F 157	documented in the of Clinical Notes writted dated 10/27/14 at 11 date of 10/24/14 real incident that occurre	olinical record.  In by the Director of Nursing 1:38 a.m. with an effective d: "RP made aware of ed on 10/23/14."	F1	57		
	Director of Nursing vinvestigation and/or (FRI) reviews for the altercation.  On 7/16/15 at 8:40 a resident to resident and deemed comple	.m. the FRI concerning the abuse incident was reviewed				

included a nursing assistant statement which revealed the resident was found on knees on floor; resident stated she fell and was already attempting to stand up when nursing assistant approached resident; assisted to bed; called nurse and reported it (fall). An investigation note written by LPN-A included a "Raised area noted to left side of forehead." At 10:00 a.m. a message was left on LPN-A's voice mail to call surveyor back. LPN-A did not return surveyor's call.

An interview was conducted with the Director of Nursing (Admin-C) with the Administrator present, on 7/16/15 at 11:05 a.m. When asked if the family was notified at the time of the fall, Admin-C stated "The family was not notified at the time of fall." When asked about family (RP) notification of the resident to resident altercation, Admin-C stated, "The family was notified of the resident to resident altercation that occurred on 10/23/14." Informed Admin-C the only documented RP

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 4 of 34

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES				FC	ORM APPROVE	
STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	LTIF	PLE CONSTRUCTION		MB NO. 0938-039 (X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	1		G		COMPLETED	
	ı	495342	B. WING	·		<b>министрум</b>	C	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CC	DE	07/16/2015	
YORK C	ONVALESCENT CENT	TER	JOSEPHINOCHEAN	***************************************	113 BATTLE ROAD			
					YORKTOWN, VA 23692			
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F 157	Continued From page	ane 4	F 1:	157	7	Control (S) (Inner) (S) (Inner) (S) (Inner) (S)	enterediscus (A. A. Constituti de de de de esperante esta esta de la constitución de la constitución de de est	
		ng the resident to resident	8 ×	l D r	1			
	altercation was writt	tten by her, entered in the						
		0/27/14 with an effective date was the day after the						
		copies of the internal						
	investigation was re	equested, Admin-C declined to						
		hen asked what the nursing ocumentation after a fall,						
	Admin-C stated "Po							
		uding vital signs is expected."						
	Review of the facility PROGRAM" include	ty "FALL PREVENTION ed:						
	Resident Falls:							
		ences a fall, a complete I identify further preventative						
	strategies	identity identifier preventative						
	Physician and respo	onsible party should be						
	notified Proper documentation	ion should be entered in the						
	"Nurses' Notes" inclu	uding follow-up and						
	resolution.							
	The facility staff did r information regarding	not present any further ng the findings.						
f	Complaint Deficiency	y.						



PRINTED: 07/28/2015

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F 157	Continued From pa		F 1	57			
	physician ordered M constipation) in Jun	used 14 doses of her daily firalax (a medication for e 2015 and 13 doses in July 1's physician was not					
	informed the Mirala: due to the resident's	x was not being administered					
	facility 11/11/13. He fibrillation, deep ven hypertension, gastro	ale, was admitted to the r diagnoses included atrial ous thrombosis, pesophageal reflux disease, s, and peripheral neuropathy					
	Resident #11's most set) with an ARD (as 5/14/15 was coded as h was able to make he Resident #11 was alsextensive assistance for her activities of dialways incontinent of H0600. Bowel Patter constipation present.	recent MDS (minimum data assessment reference date) of as a quarterly assessment, aving no memory deficits and er own daily life decisions, so coded as requiring e of one to two staff members aily living. Resident #11 was f urine and bowel. Section H, ns, was coded as no					
į	a plan of care dated a Risk, "Resident is at to inadequate fluid ar medications known to reduced physical mol	Approaches read, "Provide					
(	On 7/16/15 at 11:30,	an interview was conducted					District description of the second

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with Resident #11 while she was sitting outside in her wheelchair. During the interview, Resident #11 stated, "I don't need that Miralax. They [the nurses] prepare and offer it to me, and I just keep

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 6 of 34

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CENTERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVEI OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION 4G	(X3) DATE SURVEY COMPLETED
	495342	B. WING		C 07/16/2015
NAME OF PROVIDER OR SUPPLIER  YORK CONVALESCENT CENTI	ER		STREET ADDRESS, CITY, STATE, ZIP CO 113 BATTLE ROAD YORKTOWN, VA 23692	DE 07/16/2015
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD'RE COMPLETION
usually very regular, she would request so Review of Resident # a current signed phys Miralax 17 grams/dos Day for Constipation.  Review of the MARs records) revealed the Medication Notes who "June 2015- Miralax re 6/12, 6/13, 6/14, 6/15 6/26, 6/21, 6/30.  July 2015 - Miralax re 7/5, 7/6, 7/7, 7/8, 7/9, A thorough review of i record revealed no do physician was informed frequently not administ ordered Miralax per the On 7/16/15 at 11:45 a (registered nurse) A, with the frequent refusals of whether the physician "No, the physician has said with frequent medical needed) order from the option for Resident #1	t #11 said her bowels were and if she felt constipated ome Milk of Magnesia.  #11's clinical record revealed sician's order, "1/6/15, se Powder, Oral Every One Mix with 6 ounces water."  (medication administration e following Non -PRN ich read:  refused on 6/9, 6/10, 6/11, 6/16, 6/17, 6/18, 6/24,  fused on 7/1, 7/2, 7/3, 7/4, 7/11, 7/12, 7/13, 7/16."  Resident #11's clinical ocumentation Resident #11's ed that Resident #11 was stered the daily physician he resident's request.  .m., the unit manager, RN was interviewed regarding of Miralax and asked was aware. RN A stated, so't been notified." RN A dication refusals, a PRN (as e physician could be an 1.  Medication Administration	F 15	7	

FORM CMS-2567(02-99) Previous Versions Obsolete

medication are withheld or refused, the physician

and responsible party are notified and

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 7 of 34



## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 07/28/2015 FORM APPROVED OMB NO. 0938-0391

<u>CENTE</u>	RS FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
Minist Cymlen (1916-197) all a christyn a brand ar oedd ar oed		495342	B. WING_		C 07/16/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	V//10/4013	
YORK C	CONVALESCENT CEN	TER	Merchantherous de suppremise	113 BATTLE ROAD YORKTOWN, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRED TO THE APPROPRIED TO THE	LD BE COMPLETION	
F 157	Continued From pa		F 15	7	MPROMANDA ON CONTRACTOR STATEMENT OF THE	
	documentation of n	notification is made."				
F 241 SS=D	corporate consultar of the staff to inform the frequent refusal medication, 7/16/15 information was pro 483.15(a) DIGNITY	director of nursing, and nts were advised of the failure n Resident #11's physician of I of a daily physician ordered at 12:55 p.m. No additional ovided.  AND RESPECT OF	F 24°	The dates of completion serve as malegation of compliance.	ny	
	manner and in an er enhances each resi	omote care for residents in a nvironment that maintains or ident's dignity and respect in s or her individuality.		1. Resident #4 was assessed with a negative outcomes related to being ice cream by a standing staff memb. The CNA responsible was reeducate on dignity and respect of individuality.	fed per. red	
	by: Based on observation documentation and of facility staff failed for in a sample of 19 resliving experience.  1. Resident #4 was	ion, staff interview, facility clinical record review, the rone resident (Resident #4) sidents, to provide a dignified observed being fed a snack e CNA (certified nursing		2. The Assistant Director of Nursing/Designee has observed resident feeding practices by staff to ensure residents are treated with dig and respect. The charge nurse on eshift will be responsible for monitoring feeding practices throughout the factor ensure residents are provided a dignified living experience.	gnity each ing	
	The findings included Resident #4 was adm 10/2/13 with the follow	over the resident.		3. RNs, LPNs and CNAs will be reeducated by the Nursing Education and Training Coordinator on "Dignity and Respect of Individuality". The inservice includes but is not limited to feeding techniques to include sitting while assisting residents with eating promoting a dignified living experience.	y o and	
i.	Resident #4's most re	ecent MDS (minimum data sessment reference date) of		promoting a dignilled living expending	ue.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 8 of 34



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DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES		<b>§</b>		D: 07/28/20
CENT	ERS FOR MEDICARE	E & MEDICAID SERVICES		(	FOR MR NIC	M APPROVI <u>O. 093</u> 8-03
STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
		495342	B. WING_			C
NAME OF	PROVIDER OR SUPPLIER	disconnection of the second contract of the s		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>  U</u>	7/16/2015
YORK	CONVALESCENT CENT	TED	Mademarka	113 BATTLE ROAD		
				YORKTOWN, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O RE	(X5) COMPLETIO DATE
	Resident #4 was conterm memory loss, a with daily decision in also coded as required assistance of one to activities of daily living eating. Resident #4 incontinent of bowel on 7/15/15 at 2:50 For observed in the activities to have super choking. CNA (A) we resident, standing over common to her mouth on 7/15/15 at 2:55 For feeding the resident. About it (sitting down thought about it."  Review of the facility as followed: "The factor residents in a manner maintains or enhanced and respect in full reconditional point in a manner of the facility of the f	as a quarterly assessment.  Indeed as having short and long and requiring total assistance making. Resident #16 was iring extensive to total or staff members to performing, such as dressing and if was coded as being and bladder.  PM, Resident #4 was vities room for ice cream. It is record noted the resident revision for all meals due to was feeding ice cream to the ever her while spooning the ice that it is a sked about a company of the	F 24	4. The Assistant Director of Nursing/Designee will monitor five feeding activities, which includes mealtime, per week for six weeks to ensure that staff are not providing feeding assistance while standing unthe Director of Nursing/Designee was review findings and report any trensor variances to the CQI committee of at least a quarterly basis.	up. vill ids	8/27/15 & ongoing
F 278 SS=D	483.20(g) - (j) ASSES ACCURACY/COORD	SSMENT DINATION/CERTIFIED	F 278	The dates of completion serve as my allegation of compliance.	<b>y</b>	:

FORM CMS-2567(02-99) Previous Versions Obsolete

The assessment must accurately reflect the

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 9 of 34



## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 07/28/2015 FORM APPROVED OMB NO. 0938-0391

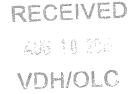
ĺ		: & MEDICAID SERVICES			OMB N	VO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) i	(X3) DATE SURVEY COMPLETED	
		495342	B. WING		Tra-	C 07/16/2015	
	PROVIDER OR SUPPLIER	ΓER		STREET ADDRESS. CITY, STATE, ZIP 113 BATTLE ROAD YORKTOWN, VA 23692	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 278	Continued From page 9 resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the			1. The MDS for Resident #. ARD of 6/18/15, Section I, a diagnosis I65000 was corresplect the diagnosis of Glam MDS coordinator was reed the importance of coding al diagnosis on the MDS.	Active ected to ucoma. The ucated on	7/24/15	
	Each individual who assessment must si that portion of the as	completes a portion of the gn and certify the accuracy of		<ol> <li>All MDSs completed with 30 days were reviewed for a Section I. Any discrepancie and corrected. The MDS co will be responsible for ensu- accuracy of Section I to refli- diagnosis.</li> </ol>	accuracy of s were noted cordinator ring the	8/27/15 & ongoing	
	false statement in a subject to a civil mor \$1,000 for each asso willfully and knowing to certify a material a	resident assessment is ney penalty of not more than essment; or an individual who ly causes another individual and false statement in a t is subject to a civil money		3. The corporate MDS coordinated the facility MDS on Section I. The inservice is review of the RAI manual infor coding section I. The MD coordinator will be receiving MDS training to include enrouse.	coordinator ncluded a structions OS additional	8/27/15 & ongoing	
	This REQUIREMENT by: Based on staff intervreview, the facility state accurate MDS (Minir (Resident Assessme)	is not met as evidenced riew and clinical record failed to complete an		4. The Assistant Director of Nursing/Designee will review MDSs completed weekly for to ensure accuracy of Section Director of Nursing/Designee findings and report any trenvariances to the CQI commit least a quarterly basis.	six weeks on I. The e will review ds or	8/27/15 & ongoing	
	For Resident #2, the Glaucoma as an Activ	facility staff failed to code /e Diagnosis.				And the second s	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 10 of 34



PRINTED: 07/28/2015

		& MEDICAID SERVICES	·		FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP IDENTIFICATION I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
NAME OF	DOWNER OF CURP FE	495342	B. WING		C 07/16/2015
NAME OF PROVIDER OR SUPPLIER  YORK CONVALESCENT CENTER			COLUMN CRITICAL COLUMN	STREET ADDRESS, CITY, STATE, ZIP CODE 113 BATTLE ROAD YORKTOWN, VA 23692	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  BC IDENTIFYING INFORMATION)	ID PREFI TAG	( The series and the series are the series and the series and the series are the series are the series are the series and the series are the	LD BE COMPLETION
F 278	Continued From page	ge 10	F 2	278	
	The findings include	ed:			
	Resident #2, a male 07/12/2009 and read	e, was admitted to the facility dmitted after hospitalization			

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/18/15 was coded as a quarterly assessment. He was coded as having short and long term memory problems and as having severely impaired decision making skills. Resident #2 was also coded as requiring total assistance of one to two staff members for all of his activities of daily living. Resident #2 was coded incontinent of urine and bowels. Section B. Hearing, Speech and Vision, B1000. Vision, was coded highly impaired, object identification in question, but eyes appear to follow objects. Section I- Active Diagnosis, 165000 Vision, was not coded for Cataracts or Glaucoma

on 03/02/2010. His diagnoses included

depression, cataracts and glaucoma.

Alzheimer's, Parkinson's, atrial fibrillation, anxiety

Resident #2 was observed in his room in bed being fed by a CNA (certified nursing assistant) on 7/15/15 at 8:15 a.m. Resident #2 was observed following requests to open his mouth and moaning as he tasted his food. Resident #2's eyes were open, clear with no sign of infection or drainage.

A review of the Resident's clinical record revealed a comprehensive care plan with the following plan of care and interventions dated 6/10/14: "Cataracts - pt. (patient) not a good candidate for cataract surgery. Glaucoma by history - monitor IOP (interocular pressure)."

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 11 of 34



PRINTED: 07/28/2015

CENTE		& MEDICAID SERVICES					RM APPROVED	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495342	B. WING	virate-metalasia	DD: 1000 cm Mr details is a season on a particular haldendraship yer responses had a particular haldendraship yer responses had been been particular haldendraship yer responses had been been particular haldendraship yer responses had been been particular haldendraship yer responses had been particular haldendraship yer responses had been particular handendraship yer response had been particular h	•	C 7/ <b>16/2015</b>	
NAME OF	NAME OF PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	***************************************	111012013	
YORK C	ONVALESCENT CEN	TER	Sind-ci-februryes accusanasa		BATTLE ROAD IKTOWN, VA 23692			
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F 278	Continued From pa	ge 11	F 2	78			Michigan (Marian and Aparlam (Marian (	
	administration of pl	rds) revealed the daily nysician ordered eye drops, (1 drop) Drops Both Eyes, one						
	"Carteolol hydrochlodrugs called beta-bl reduce pressure in t treat conditions such pressure in the eye)							
	Eye Exam consults, Notes: "3/5/15 - Diagnosis a Glaucoma-Open An HistoryIOP remain:	gleGlaucoma by s well-controlled by meds nue Ocupress OU (both eyes)						
,	(every a.mmonitor Sclerotic CataractC visually significantn	gleGlaucoma by						
( (	conducted with the ([ regarding the exclusi Cataracts as an Activ	m., an interview was DON) Director of Nursing on of Glaucoma and be Disease on the recent DS with an ARD date of						

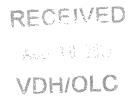
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3/20/15 and the quarterly assessment date of 6/18/15. After reviewing Resident #2's clinical

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 12 of 34



PRINTED: 07/28/2015 D 91

L/Lat / W		I VIAD LIONIVIA SEKAICES			CODM ADDROLL
<u>CENTI</u>	ERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495342	B. WING		С
NAME OF	F PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COI	07/16/2015
YORK	CONVALESCENT CENT	TER		113 BATTLE ROAD YORKTOWN, VA 23692	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	HOULD BE COMPLETION
F 278	record, the DON primodifications to refland Glaucoma under Active Diagnoses for ARD 3/20/15 and 6/20/15 and 6/20/15 and 6/20/15 and 6/20/20/20/20/20/20/20/20/20/20/20/20/20/	covided copies of MDS ect the coding of Cataracts er the Vision section of the r Resident #2's MDSs with 18/15."  E RAI User Manual, Chapter the following guidance, th medications or other rage a condition that requires be eutic efficacy or to monitor de days. A medication indicates is medication is ge an ongoing condition that for is prescribed symptoms associated with a des medications progression and medication is prescribed for ires regular staff monitoring on that condition that the prescription of the licate active  nurses monitor all rse effects as part of usual	F 27	dermanenthous to an out of control of personner was an executable despression from which demonstrate the control of the contro	
F 281 SS=D	7/16/15 at 1:00 p.m.	as informed of the findings, ICES PROVIDED MEET ANDARDS	F 281	The dates of completion serve a allegation of compliance.	ıs my
	The services provided	d or arranged by the facility			The Control of the Co

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must meet professional standards of quality.

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 13 of 34



PRINTED: 07/28/2015 ED

		AND HUMAN SERVICES				RM APPROVE
		& MEDICAID SERVICES				IO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) E	DATE SURVEY COMPLETED
		495342	B. WING			C )7/16/2015
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		77/10/2013
YORK C	ONVALESCENT CENT	TER		113 BATTLE ROAD YORKTOWN, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIEM (PROSS-REFERENCE)	ULD BE	(X5) COMPLETION DATE
F 281	by: Based on observati documentation revie in the course of a co facility staff failed for and #2) of 19 reside follow professional s  1. For Resident #15 adequately documer Resident #15 after a	ion, staff interview, facility ew, clinical record review, and emplaint investigation, the r 2 residents (Resident #15 ents in the survey sample, to standard of nursing.  i , the facility staff failed to nt, assess and monitor fall.	F 2	facility. Resident #2 has been as and there were no negative outorelated to missed medication documentation.  The nurses responsible have be reeducated on the importance of documentation of assessment a monitoring post fall. The medical nurses have been reeducated of importance of documentation of medication administration.  2. The Director of Nursing/Design	ssessed comes en f nd tion n the	8/27/15 &
	document two doses gastroesophageal re having been adminis  The findings included  1. Resident #15 was 10/7/14 with the diag Alzheimer's Demention hypertension. Reside the hospital on 10/26 removing clothes, higholding her chest. Be	afflux disease, GERD) as stered.  d: admitted to the facility on noses of, but not limited to, a, encephalopathy and ent #15 was discharged to /14 due to shaking, gh blood pressure and eing Resident #15 was not in survey, a closed record		review all falls that have occurred past 30 days to ensure that the assessment and monitoring of the resident post fall is adequately documented in the medical recording process. Director of Nursing/Designee will all medication administration recording residents for the past 30 ensure that all medications have administered as ordered and that administration is documented on medication administration recording variances will be investigated and corrective action initiated. The Assistant Director of Nursing/Designee will be responsitor ensuring the medical record	d in the  de  d. The I review ords of days to been t the . Any	ongoing

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The most recent Minimum Data Set (MDS) was

Reference Date of 10/14/14. The MDS coded

except eating which Resident #15 required no

physical assistance; physical behaviors directed towards others and other behaviors not directed

Resident #15 with severe cognitive impairment;

required set up only for all activities of daily living

an initial assessment with an Assessment

Event ID: OMY111

Facility ID: VA0282

medications.

adequately reflects the assessment

be responsible for ensuring facility

followed for the administration of

policy and professional standards are

and monitoring of the resident post fall.

The medication nurses on each shift will

If continuation sheet Page 14 of 34

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PRINTED: 07/28/2015

		I AND HUMAN SERVICES				CD. 07/28/201
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				RM APPROVE NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) I	DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER					07/16/2015
			o de la companya de l	STREET ADDRESS. CITY, STATE, ZIP CODE  113 BATTLE ROAD		
YORK C	ONVALESCENT CENT	TER				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	YORKTOWN, VA 23692  PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 14	E /	2 All DNc/LDNc will be reading	4 l l	0.10.77.14.5.0
			F 2	81 3. All RNs/LPNs will be reeduca	ted by	8/27/15 &
	intruded on the priva	dering daily that significantly acy or activities of others; had y prior to admission.		the Nursing Education and Trair Coordinator regarding fall and medication administration documentation. The inservice wi		ongoing
	On 7/15/15 at 1:50	o.m., Resident #15's clinical		include but is not limited to adeq	uate	
		d. The review revealed the		post fall assessment, monitoring	and	
	following electronic	"Clinical Notes:"		documentation. It will also includ	e the	
	Clinical Notes dated	10/26/14 at 4:48 p.m. written		importance of completion of med administration documentation.	ication	
	by LPN-A with an eff	fective date (date of				
	occurrence) of 10/28	5/14 at 4:46 p.m. read:		<ol><li>The Director of Nursing/Design</li></ol>	nee will	8/27/15 &
	"resident found on fl	oor by aide on hands and		monitor 20% of falls weekly for s	ix	ongoing
	(medical deeter) ma	ain noted at this time md de aware vitals normal left		weeks to ensure the medical rec		
	message for ro (res	oonsible party) to call back."		adequately reflects the assessme	ent and	
	There were no post the clinical record.	fall nursing assessments in		monitoring of the resident post fa Assistant Director of Nursing/Des will audit 10% of medication	signee	
	Director of Nursing v	e.m. the Administrator and vere asked to present the fall to the fall that occurred on		administration records weekly for weeks to ensure that medications been administered as ordered and documented on the medication administration record. The Direct	s have id tor of	
·	included a nursing as included the resident floor; resident stated attempting to stand uapproached resident; nurse and reported it written by Licensed a "Raised ar	m. the facility fall 1/25/14 was reviewed and sistant statement which was found on knees on she fell and was already p when nursing assistant assisted to bed; called (fall). An investigation note can noted to left side of a m. on 7/16/15 in attempt to		Nursing/Designee will review find and report any trends or variance the CQI committee on or at least quarterly basis.	es to	

interview LPN-A, a message was left on LPN-A's voice mail to call surveyor back. LPN-A did not return surveyor's call. The Director of Nursing's incident report review dated 10/27/14 listed "Nature of injury-hematoma" but no body part was

## DEPARTMENT OF HEALTH AND HUMAN OFFICE

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		AND HUMAN SERVICES			•		APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(		). 0938-039°
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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YORK C	ONVALESCENT CEN	TER			BATTLE ROAD RKTOWN, VA 23692		
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F 281	Continued From pa	ge 15	F2	81		бовен от общений в под от от общений в под общений в п	Oliver and the second s
	Nursing (Admin-C) on 7/16/15 at 11:05 family was notified a stated "The family v fall." When asked v was for documental stated "Post fall, 3 d including vital signs Administrator and D informed of the lack monitoring including clinical record of the forehead. Admin-C have a fall policy but prevention program  Review of the facility PREVENTION PRO  Resident Falls: If a resident experier investigation should strategies Physician and respondified Proper documentation." Proper documentation." Guidance given from of Nursing, Eighth Editor The data from a handallow you to collect values.	rirector of Nursing were of post fall assessments and lack of documentation in the injury to Resident #15's left stated the facility did not tidd provide a facility fall document.  If document titled "FALL GRAM" included:  Inces a fall, a complete identify further preventative insible part should be					

FORM CMS-2567(02-99) Previous Versions Obsolete

Always conduct an examination competently with a caring and culturally sensitive approach." And

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 16 of 34

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
#0000000.		495342	B. WING		C 07/16/2015
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 113 BATTLE ROAD YORKTOWN, VA 23692	07/16/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD RE COMPLETION
F 281	page 217 included: last part of a complethorough, and accurequired in recordin record an assessmenterpretation, it is lead to be caring for the precording patient stapprofessional responsible.	"Data documentation is the ete assessment. The timely, rate documentation of facts is g patient data. If you do not ent finding or problem est and unavailable to anyone eatientObserving and atus are legal and sibilities."  not present any further post information regarding the	F 2	281	
	ensure two doses of gastroesophageal redocumented as having Resident #2, a male, 7/12/09 and readmitt 3/2/10. His diagnose Parkinson's, cataractic and GERD (gastroes Resident #2's most reset) with an ARD (asset) with an ARD (a	the facility staff failed to Omeprazole (for iflux disease ) were ing been administered.  was admitted to the facility ited after hospitalization on ies included Alzheimer's, its, glaucoma, Blepharitis, its phageal reflux disease).  ecent MDS (minimum data sessment reference date) of its a quarterly assessment. It ing short and long term it das having severely isking skills. Resident #2 was ing total assistance of one to			

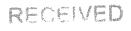
FORM CMS-2567(02-99) Previous Versions Obsolete

two staff members for all of his activities of daily

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 17 of 34



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PRINTED: 07/28/2015

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES					RM APPROVE
1	TOF DEFICIENCIES		1			1	<u>IO. 0938-039</u>
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		OATE SURVEY OMPLETED
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YORK C	ONVALESCENT CENT	TER			13 BATTLE ROAD		
		See 3 %		Y	ORKTOWN, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X5) COMPLETION DATE
F 281	Continued From pa	ine 17	F 2	121		MODERNA SALLA CASSAGRADA	Namenessia in visit substituti en
		was coded incontinent of	2 K.,	01			
	physician order date be administered On	ical record revealed a ed 4/20/15 for Resident #2 to neprazole (Prilosec), 20 nilliliters suspension, by mouth ay.					
	administration recort 7/10/15, Prilosec was been administered. equal signs "=" were According to the MA medication was Prewas no documentation 7/9/15 or 7/10/15 on	2015 MAR (medication rd) revealed on 7/09/15 and as not documented as having For the dates in question, a documented on the MAR. AR Legend, "=" indicated the viously Scheduled. There ion regarding Prilosec on the NON PRN Medication is significance of the "=" signs.					
	07/16/15 at approxin reviewing the clinical was no way of know administered on 7/9/added, "The expectato put in her initials a medication." The DC contact the two nurse	ON said she was unable to					
	numerous different p resources for develop	ping their professional g. A specific professional					

FORM CMS-2567(02-99) Previous Versions Obsolete

Review of the facility's Medication Administration

Event ID: OMY111

Facility ID: VA0282

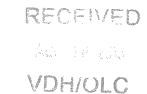
If continuation sheet Page 18 of 34

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2015 FORM APPROVED OMB NO 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495342	B. WING		C 07/16/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
YORK C	CONVALESCENT CEN	TER	Майдайн жөгүүүүн алаанаа	113 BATTLE ROAD YORKTOWN, VA 23692	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 281	Continued From pa	ge 18	F 2	31	Oto Commencia de la composiçõe de la com
	the person administ space provided und	esident's MAR/TAR tration Record) is initialed by trating a medication in the er the date, and on the line for tion dose administration.			
F 283 SS≂D	was given to nursing Nursing 7th Edition, administering a med on the appropriate n	TICIPATE DISCHARGE:	F 28	The dates of completion serve as allegation of compliance.	my
SS=D R W m re	must have a dischar recapitulation of the summary of the residual.	When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items		1. The discharge summary has be completed for resident #14 and file the resident's discharge record.	en 7/24/15 ed in
	in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.			<ol> <li>The Director of Nursing/Designer review clinical records of all discharesidents for the past 30 days to eathe discharge summary has been completed and is located in the closest</li> </ol>	arged ongoing nsure
	by: Based on staff interview the facility sta (Resident #14) of 19	T is not met as evidenced view and clinical record ff failed for 1 resident residents in the survey		record. The Director of Nursing/Designee be responsible for ensuring discha summaries have been completed i accordance with facility policy.	will rge
	sample to ensure a dicompleted.	lischarge summary was		<ol> <li>Physicians and providers will be reeducated on the importance of completing the discharge summary</li> </ol>	ongoing
	The findings included Resident # 14, an 80 the facility on 12/10/1 dementia and depres	year old, was admitted to  4. Her diagnoses included		inservice includes but is not limited content required for a complete and accurate discharge summary, timeliness of completion and review the facility's policy.	to d



## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2015 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				RM APPROVE 10. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) [	DATE SURVEY COMPLETED
		495342	B. WING		erinder-demons	C 07/16/2015
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE  113 BATTLE ROAD  YORKTOWN, VA 23692	E TO A CONTRACTOR OF THE PROPERTY OF THE PROPE	J1/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 283	was an initial asses coded with a Brief In score of 6 indicating She required extens activities of daily livi  Resident #14 was d 1/22/15. Both the e the clinical record w record did not include On 7/16/16 at 11:00 stated that she had	simmum Data Set assessment sement. Resident #14 was interview of Mental Status g severe cognitive impairment, sive assistance with her ing.  It is charged from the facility on electronic and paper parts of vere reviewed. The closed de a discharge summary.  It a.m., the Director of Nursing checked with the physician's	F 28:	4. The Director of Nursing/Design review the medical record of all residents who have been dischar from the facility weekly for six we ensure that the discharge summa been completed. The Director of Nursing/Designee will review find and report any trends or variance the CQI committee on or at least quarterly basis.	rged eeks to ary has lings es to	8/27/15 & ongoing
	office and found that not been completed	at a discharge summary had !. :ARE/SERVICES FOR	F 309	The dates of completion serve as allegation of compliance.	my	
	provide the necessa or maintain the higher mental, and psychos	receive and the facility must ary care and services to attain est practicable physical, social well-being, in comprehensive assessment		1. Resident # 3 was assessed with negative outcomes related to administration of insulin. Residen was assessed with no negative outcomes related to eye treatment physician and the responsible part were notified. The insulin order was corrected immediately and the eye	t # 2 t. The ties as	7/24/15
	by: Based on observation record review the fact (Resident #3 and Re	T is not met as evidenced on, staff interview and clinical cility staff failed for 2 resident esident #2) of 19 residents in ensure physician orders		treatment was reordered by the pr physician. The nurse involved wa reeducated on scheduling of insul orders in the EHR. The nurse invo- with the eye treatment was reeduc on review of consultation notes.	imary s lin olved	
		ived insulin coverage in the tdinner time and insulin was				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 20 of 34

RECEIVED

PRINTED: 07/28/2015 91

CENTE		& MEDICAID SERVICES			FOR	M APPROVE
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS OFTWO TATE THE SECOND	0	7/16/2015
			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
YORK C	ONVALESCENT CENT	rer .	1	113 BATTLE ROAD YORKTOWN, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	implement and perfetreatment.  The findings include  1. Resident #3, a 97 the facility on 11/2/1:	the facility staff failed to orm a physician ordered eye d:  1 year old, was admitted to 2. His diagnoses included	F 309	2. The Director of Nursing/Design has reviewed the medication administration records of current residents for the past 30 days to that all insulin orders are accurate have been scheduled in accordar with the physician order. The Directory Nursing/Designee has reviewed a ophthalmology progress notes for current residents within the last 3 to ensure all new orders have been implemented.	ensure e and nce ector of all - 0 days	8/27/15 & ongoing
	assessment was a quassessment reference coded with a Brief In score of 15 indicating He required extensivactivities of daily living Resident #3's clinical	recent Minimum Data Set puarterly assessment with an ce date of 5/6/15. He was terview of Mental Status g no cognitive impairment. re assistance with his ng.		3. RNs/LPNs will be reeducated order entry and review of consultanotes. The inservice will include not limited to proper scheduling order and the importance of revierall consulting physicians progress to ensure orders are initiated as ordered.	ation out is f s wing	8/27/15 & ongoing
	note from the Nurse read "Problem: BS (b (diagnosis) HX (histo Mellitus), On Lantus and the morning) Lantus 38 b (every night). Humald at lunch + dinner if BS (blood 13 U (units) SQ (subodinner if BS (blood subonote written by the I	Practitioner dated 1/15/15 blood sugar) uncontrolled Dx blood sugar) uncontrolled Dx blood sugar) and every USQ (subcutaneous) q pm blood sugar) > 180". "1) malog 10 U (unit) with lunch blood sugar) > 180 2) Humalog butaneous) with lunch and		4. The Director of Nursing/Design audit 20% of all new insulin orders weekly for six weeks to ensure insulated has been scheduled according to physicians order. The Director of Nursing/Designee will audit 20% cophthalmology consultation notes weekly for six weeks to ensure an all new orders are implemented ar performed. The Director of Nursing/Designee will review finding and report any trends or variance the CQI committee on or at least a quarterly basis.	sulin the of all y and nd ngs s to	8/27/15 & ongoing

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List" section of the note. The insulin orders read:

2) Humalog 10 units twice a day before lunch and

1) Lantus 65 units subcutaneous daily

Event ID: OMY111

Facility ID: VA0282

quarterly basis.

If continuation sheet Page 21 of 34

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CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES					0. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED
		495342	B. WING	~~~			C 7/46/2045
	PROVIDER OR SUPPLIER  ONVALESCENT CEN		and the state of t	113	EET ADDRESS, CITY, STATE, ZIP CODE BATTLE ROAD RKTOWN, VA 23692	1 0	7/16/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	(Diabetes Mellitus, insulins, routine Hg monitoring".  Resident #3's July 2 Administration Reconstruction Included was Humat two times daily start included a parameter sugar) is greater that give 13 u (units)." The Humalog on the 12-2 p.m." and "Even In addition to the Humalog on the evening med pass, parameter the evening med pass. The 11 dates and bled documented on the second pass and bled documented on the second pass.	every afternoon.  n" section read "1. DM II type 2)- stable, continue bA1c (blood sugar test)  2015 Medication ord (MAR) was reviewed. alog 13 units Subcutaneous ting 3/26/15. The order er that read "If BS (blood at 180 at lunch & dinner then the administration times for MAR were "Midday Medpass ening Med pass 8-10 p.m."  Imalog being administered at as rather than at the dinner ers were not followed during ses. For the month of July amalog were administered on Resident #3's blood sugar not should have been held.	F 3	09			

FORM CMS-2567(02-99) Previous Versions Obsolete

7/13/15= 91

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 22 of 34



## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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	The state of the s	a MICDIONID SEKVICES			<u>OMB NO. 09</u> 38-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
BIARAC OF	OPO PRED OR ALICO PER	495342	B. WING		C 07/16/2015
	PROVIDER OR SUPPLIER  ONVALESCENT CENT	rer		STREET ADDRESS, CITY, STATE, ZIP CODE 113 BATTLE ROAD YORKTOWN, VA 23692	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	(======================================	DBE COMPLETION
F 309	Continued From page 7/14/15= 148	ge 22	F3	609	

Parameters were followed appropriately for the lunch time Humalog administration. On 7/16/15 at 10 a.m., Registered Nurse A (RN A) was asked how the nurses documented that a medication was held. She stated that the system would prompt them to choose a code or to write a note.

On 7/15/15 at the end of day meeting, the Director of Nursing (DON) was asked why Resident #3 received Humalog at the evening med pass when the order specified that the Humalog should be given with lunch and dinner. It was reviewed with the DON that on 7/2/15 the Physician Assistant charted that Resident #3 was receiving 10 units of Humalog and should continue with that dose. The DON was also notified that parameters were not followed. The DON was asked to clarify when the Humalog should be given and at what dose.

On 7/16/15 at 10:00 a.m. the DON stated that the Humalog order was supposed to be 13 units at lunch and dinner. She stated that the order had been input into the system incorrectly.

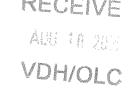
Resident #3's most recent Hemoglobin A1c (average of the blood glucose level over a 3 month period) labwork was completed on 7/8/15 with a reading of 6.9%. There were no apparent adverse effects from the insulin administration errors. A reading of 6.5% or above indicates

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Event ID: OMY111

Facility ID: VA0282

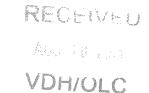
If continuation sheet Page 23 of 34



PRINTED: 07/28/2015

CENTE		VIAD LIOINWIA SEKAICES				FOR	M APPROVED
		& MEDICAID SERVICES	mgroomere accuracy.	-		MB N	O. 0938-039
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
		495342	B. WING	3			C
NAME OF	PROVIDER OR SUPPLIER		American interpretation of the second	S	STREET ADDRESS, CITY, STATE, ZIP CODE		7/16/2015
YORK C	ONVALESCENT CENT				13 BATTLE ROAD		
	OWELOOFIA! OFIA!			Y	ORKTOWN, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 309	Continued From page	de 23	r.	200	The state of the s		
		red level below 7.%.	Γ,	309			
	http://www.niddk.nih -topics/diagnostic-te ndex.aspx	.gov/health-information/health sts/a1c-test-diabetes/Pages/i					
	notified of the issues	edication error at the end of					
	2. For Resident #2, t implement and performent.	he facility staff failed to rm a physician ordered eye					
	7/12/09 and readmitt 3/2/10. His diagnose Parkinson's, cataract	was admitted to the facility ed after hospitalization on es included Alzheimer's, is, glaucoma, Blepharitis, ophageal reflux disease).					
1	with successful treatr frequently is chronic : with eyelid scrubs."	mation of the eyelids. Even ment, the condition and requires daily attention diseases-conditions/blepharit					
\$ \$ \$ \$ 1	set) with an ARD (ass 6/18/15 was coded as He was coded as hav nemory problems an mpaired decision ma	ecent MDS (minimum data sessment reference date) of s a quarterly assessment. ing short and long term d as having severely king skills. Resident #2 was ng total assistance of one to					

two staff members for all of his activities of daily living. Resident #2 was coded incontinent of



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<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO 2020 222
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495342	B. WING		C
	PROVIDER OR SUPPLIER  ONVALESCENT CEN	TER		STREET ADDRESS, CITY, STATE, 2 113 BATTLE ROAD YORKTOWN, VA 23692	<b>07/16/2015</b> ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 309	and Vision, B1000.	Section B. Hearing, Speech Vision, was coded highly	F3	109	
	eyes appear to follo	ntification in question, but w objects.			
	being fed by a CNA on 7/15/15 at 8:15 a observed following r and moaning as he	(certified nursing assistant) .m. Resident #2 was equests to open his mouth tasted his food. Resident of clear with no sign of			
	conducted during the comprehensive care Present) included a p "Vision: Resident ab Highly Impaired, +GI	plan (effective 1/15/2015 - plan of care which read, ility to see adequate light is			
,	treatment orders follo consultations: "Summary Ocular P "3/5/15 - Diagnosis a 1. Glaucoma-Open HistoryIOP remains	rogress Notes- nd Treatment: AngleGlaucoma by well-controlled by press OU (both eyes) g			
•	ophth susp: 1 gtt (dro 10 days, then Artificial day) - OUcontinue d	nous /moderateInitiate Tobradex p)-QID (4 times a day)-OU x I tears: 1 gtt-BID(twice a aily lid scrubsmonitor 1-2 ation: April 2015 for Lid			

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Check. The nurse practitioner 's signature and

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 25 of 34

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	RM APPROVED 10. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) C	DATE SURVEY COMPLETED
		495342	B. WING				C 07/16/2015
NAME OF	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	Service Control of the Control of th	
YORK C	ONVALESCENT CENT	TER	one in Assessment of		3 BATTLE ROAD ORKTOWN, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 309	Continued From pa	~	F 3	09			no Ostopoli demo in cili. Si mana ance anno con cine de mana con cine con en
	date (9/22/14) were	written on the consult					
	HistoryIOP remain	AngleGlaucoma by is well-controlled by upress OU (both eyes) q					
	Artificial tears: 1 gtt then Artificial tears:	nous d/moderateContinue (drop)-QID-OU x 10 days, 1 gtt-BID(twice a day) - .id Scrubsmonitor 6 months.					į
	significantmonitor (	-OU-Mild/stablenot visually 6 months. Next Examination Glaucoma follow-up."					
	Administration Reco- ordered eye drops had ordered. Review of and July 2015 TARs	t #2's (MARs) Medication rd revealed the physician ad been administered as the March, April, May, June (Treatment Administration real the physician ordered d Scrubs.					
	Lid Scrubs on 7/15/1 provided a copy of ar with a physician's ord "Blepharitis OUCondampened wash clot to 8 drops of baby sh (every) am OU (both nurse practitioner 's s	pout the physician ordered 5 at 15:30 p.m., the DON in Eye Exam dated 9/18/14 der for the Lid Scrubs: stinue Lid Scrubs with in diluted baby shampoo (4 pampoo in 1/2 cup of water) queyes) indefinitely. "The signature and date (9/22/14) onsult. The DON requested					

time to review Resident#2's clinical record to see

if the Lid Scrubs were ever implemented.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495342	B. WING		C
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	07/16/2015
YORK (	ONVALESCENT CEN	ΓER		113 BATTLE ROAD YORKTOWN, VA 23692	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE  X (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 309	Continued From pa	ge 26	F 3	09	
	clinical record, the Edocumentation the process for daily Lid Scrubs performed. The DC physician to see if the have the Lid Scrubs reinstate the Lid Scrubs reinstate the Lid Scrubs SCRUB COMPLIAN Eyes. One Time Dail Instructions: Clean warm soapy water."  The DON was unable physician's order for 9/22/14, and reorder	a.m., after reviewing the DON said there was no obysician ordered treatment was ever initiated or DN stated, "I contacted the e want him (Resident#2) to . The doctor wanted to tubs." The following provided, "7/16/15, LID ICE with Lint Free Pads, Both Ity Starting 7/16/2015. with baby shampoo and the to provide evidence the Lid Scrubs ordered on the tube continued on 3/5/15 was ever implemented by			
F 333	Patricia A. Potter and Inc; page 419 stated responsible for direc Nurses are obligated	ting medical treatment. to follow physician's orders he orders are in error or	F 33	3 The dates of completion serve as	s mv
SS=D	SIGNIFICANT MED	ERRORS	F 33	allegation of compliance.	S IIIy
	The facility must ensi any significant medic	ure that residents are free of ation errors.			
	by:	is not met as evidenced n, staff interview, facility			

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		AND HUMAN SERVICES  & MEDICAID SERVICES			FORM APPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495342	B. WING		C 07/16/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
YORK	ONVALESCENT CENT	ER		113 BATTLE ROAD YORKTOWN, VA 23692	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
F 333	Continued From pa	ge 27	F 3:		
	the facility staff faile of 19 residents in the residents were free errors.  1. Resident #3 receivening instead of a	ew and clinical record review d for 1 resident (Resident #3) e survey sample to ensure from significant medication sived insulin coverage in the at dinner and insulin was not s as per physician ordered		1. Resident #3 was assessed and not demonstrated any adverse out related to insulin administration. Tresponsible party and physician habeen notified of the medication err. The nurses involved have been reeducated on medication administration to include insulin or and parameters.	come The ave or.
	The findings include  1. Resident #3 rece evening instead of a held per physician o  Resident #3, a 91 ye	ived insulin coverage in the t dinner and insulin was not redered parameters.		2. The Assistant Director of Nursing/Designee will review 100% insulin orders for all current resider ensure that the administration time consistent with the physicians order the medication administration record for the past 30 days will be reviewed ensure that medications have been administrated as archaed and ball.	nts to es are er. ords ed to
	facility on 11/2/12. His diagnoses included diabetes and congestive heart failure.  Resident #3's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 5/6/15. He was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. He required extensive assistance with his activities of daily living.			administered as ordered and held according to parameters, if indicate The charge nurse on each shift will responsible for reviewing the insuli orders to ensure they are schedule according to the physician order. To charge nurse on each shift will reviet the medication administration record ensure medications have been administered according to the physician order.	be n ed he ew rds to

Resident #3's July 2015 Medication

Administration Record (MAR) was reviewed. Included was Humalog 13 units Subcutaneous two times daily starting 3/26/15. The order included a parameter that read "If BS (blood sugar) is greater that 180 at lunch & dinner then give 13 u (units)." The administration times for the Humalog on the MAR were "Midday Medpass 12-2 p.m." and "Evening Med pass 8-10 p.m." The evening Humalog should have been

order.



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		I VIAD LIDINIVIA SEKAICES			FORM APPROVE
<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES	en agentonia construir de la c		OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
	,	495342	B. WING		C
NAME OF !	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	07/16/2015
			произонения	113 BATTLE ROAD	
YORK C	ONVALESCENT CENT	rer	Name of the state	YORKTOWN, VA 23692	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL	LD BE COMPLETION
F 333	Continued From pa	ana 78	E 3	333 3. RN/LPNs will be reeducated by	1ha 0107145 0
•	administered at dinr	-	r J	Nursing Education and Training Coordinator/Designee on the "Six	the 8/27/15 & ongoing
	In addition to the Huthe evening med (n	umalog being administered at nedication) pass rather than at		Rights of Medication Administration The inservice will include but is not	
	the dinner med pass	ss. Parameters were not		limited to a review of order entry in	
	followed during the	evening med pass. For the		EHR to ensure medications are	
	month of July 2015,	, 13 units of Humalog were		scheduled according to the physici	
		occasions when Resident as less than 180. The		order. It will also include following to physicians order as it pertains to	the
		as less than 180. The live been held on these 11		holding medications according to	
	occasions.	TO DOG! HOW OR HIGGS 1,		parameters.	
	documented on the Evening Med-Pass 8	lood sugar readings were July 2015 MAR during the " 8-10 pm " as follows:		4. The Director of Nursing/Designe review 10% of new orders weekly tweeks to ensure that medications a	for six ongoing
	7/1/15= 112 milligra 7/4/15= 89	ims/deciliter		scheduled according to the physici order. The Assistant Director of	ians
	7/5/15= 176 7/6/15= 170			Nursing/Designee will review 10%	of
	7/0/15= 170 7/7/15= 134			medication administration records weekly for six weeks to ensure	
	7/9/15= 132			medications have been administere	ed or
	7/10/15= 168			held according to the prescribed	
	7/11/15= 86 7/12/15= 123			parameters. The results of the audi	
	7/12/15= 123 7/13/15= 91			will be reviewed and corrective acti	ion
	7/14/15= 148			taken if needed. The Director of Nursing will report findings to the C committee on at least a quarterly be	
i	As documented on the followed appropriated administration.	the MAR, parameters were ely for the lunch time Humalog			
r	<ul> <li>A) was asked how the medication was held.</li> </ul>	m., Registered Nurse A (RN ne nurses documented that a l. She stated that the system to choose a code or to write a			

note.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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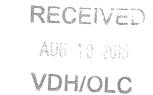
		E & MEDICAID SERVICES			O!	MB NO. 0938-039
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495342	B. WING	e veltaalamisellessam. Mettel (1980–1975 ) (4.) (4.) Poljojoponydolokossamiselless		C 07/16/2015
	PROVIDER OR SUPPLIER		and the control of th	STREET ADDRESS, C	CITY, STATE, ZIP CODE	UI/IVIZVIJ
	CONVALESCENT CENT			YORKTOWN, VA	23692	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	FR'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 333	Director of Nursing Resident #3 receive med pass when the Humalog should be The DON was also not followed. The D the Humalog should On 7/16/15 at 10:00 Humalog order is su	end of day meeting, the (DON) was notified that ed Humalog at the evening e order specified that the egiven with lunch and dinner, notified that parameters were DON was asked to clarify when d be given and at what dose.  It is a contraction of the proposed to be 13 units at the proposed to be 15 units at the proposed to the proposed to the proposed to the proposed to th	F 33	13		
	wrong on the MAR be input into the system.  Resident #3's most is (average of the bloomonth period) labwed with a reading of 6.9 adverse effects from errors. A reading of diabetes with a desire http://www.niddk.nih.	recent Hemoglobin A1c od glucose level over a 3 ork was completed on 7/8/15 own. There were no apparent the insulin administration 6.5% or above indicates				
F 425 SS=D	notified of the issues management and me day meeting on 7/16/ 483.60(a),(b) PHARM ACCURATE PROCE	edication error at the end of /15. MACEUTICAL SVC -	F 425	The dates of con allegation of com	mpletion serve as my npliance.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 30 of 34



## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2015 FORM APPROVED OMB NO 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495342	B. WING		C
	PROVIDER OR SUPPLIER  ONVALESCENT CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 113 BATTLE ROAD YORKTOWN, VA 23692	07/16/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	ULD BE COMPLETION
F 425	Continued From page 30 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and			1. Resident #2 has been assessed no negative outcomes related to Omeprazole dose. The medication supply has been checked to ensure availability for future doses. The responsible were reeducated on importance of monitoring expiration dates to ensure medication is recitimely to avoid missed doses.	missed on ure nurses the ion ordered
	administering of all the needs of each re The facility must em a licensed pharmac	drugs and biologicals) to meet esident.  uploy or obtain the services of ist who provides consultation provision of pharmacy		2. The Assistant Director of Nursing/Designee has checked the medication supply for all current residents to ensure all medication available for administration. The medication nurse on each shift with responsible for ensuring that medications are available for the scheduled dose and reordering medications prior to expiration day	ns are ill be next
	by: Based on staff inter review, the facility st medications were av one resident (Reside survey sample.  For Resident #2, the	vailable for administration for ent #2) of 19 residents in the ent #2 and the ent #2 are facility staff failed to ensure strointestinal reflux disease)		3. The Nursing Education and Tr. Coordinator has reeducated RNs/ on "Pharmaceutical Services". Th inservice included but was not lim a review of the procedure for reormedication from pharmacy prior to expiration date and checking to er an adequate supply is available.	/LPNs ongoing le lited to dering
	The findings included	d:			Total condensate of the content of t
\$ 7 3	7/12/09 and readmitt 3/2/10. His diagnose	was admitted to the facility ed after hospitalization on es included Alzheimer's, rillation, anxiety depression,			

FORM CMS-2567(02-99) Previous Versions Obsolete

cataracts, glaucoma and gastrointestinal reflux

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 31 of 34



PRINTED: 07/28/2015

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(		M APPROVEI 0. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
		495342	B. WING	,			C
NAME OF	PROVIDER OR SUPPLIER		D. WING	-		0	7/16/2015
	The state of the s			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
YORK C	ONVALESCENT CEN	TER		ž.	113 BATTLE ROAD YORKTOWN, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	D BE	(X5) COMPLETION DATE
E 406	O-Minus Francis	^4				where the second and the second	
F 420	Continued From pa	ge 31	F4	425			~ . ~
	disease (GERD).				4. The Assistant Director of		8/27/15 &
	Resident #2's most	recent MDS (minimum data			Nursing/designee will review on a weekly for six weeks 10% of all cu	ırrent	ongoing
	set) with an ARD (a	ssessment reference date) of			residents medication supplies to e		
	6/18/15 was coded as a quarterly assessment.  He was coded as having short and long term				all ordered medications are available		
					administration. The Director of Nur		
	memory problems a	and severely impaired decision			will review findings for any trends of	or	
	requiring total accie	dent #2 was also coded as tance of one to two staff			variances and report to the CQI	ooio	
	members for all of h	nis activities of daily living.			committee on at least a quarterly b	asis.	
	Resident #2 was co bowels.	ded incontinent of urine and					
	A review of the clini	cal record revealed a					
	physician order date	d 4/20/15 for Resident #2 to					
	oe administered Om millieguivalents/5 mi	neprazole (Prilosec), 20 illiliters suspension, by mouth					
	for GERD once a da	iy.					
	A review of Resident	t #2's July 2015 MAR					
	(Medication Adminis	tration Record) revealed					
	Prilosec was not adr	ministered on 07/11/15. A					
	note by the medicati	on nurse on 7/11/15 read,					
	Administered."	Pharmacy aware. Not					
		nducted with the DON					
	(director of nursing)	on 07/16/15 at approximately					окаурунальны
	9:30 a.m. After revie	wing the clinical record, the					NORMAN
1	JON Salu life MillOSE  Nas expired and the	ec was the liquid form and night shift nurse reordered it					**************************************
•	on 7/11/15. "The Pri	losec wasn't available for the					

scheduled dose on 7/11."

The facility administration was informed of the findings during a briefing on 7/16/15 at approximately 12:50 a.m. The facility did not present any further information about the findings.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2015 FORM APPROVED OMB NO. 0938-0391

4		& MEDICAID SERVICES	rage-rational arthresis-section and acceptance	-	O	MB N	O. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495342	B. WING		NOTE OF THE PROPERTY OF THE PR	0.	C <b>7/16/201</b> 5
NAME OF	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
YORK C	ONVALESCENT CENT	TER	New contrast of the last of th		3 BATTLE ROAD DRKTOWN, VA 23692		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 502	Continued From pa	ge 32	F 50	02			
F 502			F 50	00	The dates of completion serve as n	ny	
SS=D	The facility must pro	ovide or obtain laboratory			allegation of compliance.		
		e needs of its residents. The e for the quality and timeliness			1. Resident #4's physician was not regarding the hemocult testing ord in January was not performed. The physician evaluated the resident's	dered	7/24/15
	by: Based on staff inter review, the facility st	IT is not met as evidenced view and clinical record taff failed for one of 16 #4) in the survey sample to			current labs and status and discontinued the order. RNs/LPNs have been reeducated on the proc for obtaining and documenting hem stool specimens as ordered.	ess	
	stool for hidden bloc the physician.  The findings include  Resident #4 was add	have an hemoccult (testing of od) times three as ordered by d:			2. A 100% audit of current resident will be conducted for the past 30 dato identify any variance with ordered labs. The physician will be notified of findings and any change in orders be completed. The lab tracking log be reviewed daily by the Charge Nurse/Designee to ensure that labs	ays d of will will	8/27/15 & ongoing
	fibrillation, high blood anemia and stroke. Resident #4's most r set) with an ARD (as	ewing diagnoses: Atrial dipressure, seizure disorder, ecent MDS (minimum data sessment reference date) of		; ;	including hemocults have been obtained as ordered and that physic are notified of the results. If there ar variances, the physician will be notif	re fied.	8/27/15 & ongoing
	Resident #4 was cooterm memory loss, a with daily decision malso coded as require assistance of one to	staff members to perform g, such as dressing and was coded as being		1 ) {	<ol> <li>RN/LPNs were reeducated by the Nursing Education and Training Coordinator/Designee on obtaining hemocult specimens as ordered and recording results in the medical recording</li> </ol>	d	

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Review of the clinical record revealed a

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 33 of 34



PRINTED: 07/28/2015 ED 91

		AND HUMAN SERVICES  & MEDICAID SERVICES			FC	)RM APPROVE NO. 0938-03:
STATEMENT OF DEF	ICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LTIPLE CONSTRUCTION DING	(X3)	DATE SURVEY COMPLETED
		495342	B. WING			C 07/16/2015
NAME OF PROVIDE	R OR SUPPLIER		- Contraction of the Contraction	STREET ADDRESS, CITY, STAT	E, ZIP CODE	Weeklinembersonensenskapanensen - Angeleinen
YORK CONVAL	ESCENT CENT	TER		113 BATTLE ROAD YORKTOWN, VA 23692		
(X4) ID PREFIX (E TAG RE	ACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
physic Ferriti and to reside anem 1/16/1 the M the nu On 7/ nursin	n level, TIBC of the check hemore of the check	ated 1/12/15 for an iron level, (total iron binding capacity) coult stools times three, as the ng signs and symptoms of samples were obtained on loccult stools were noted on administration record) or in PM, the DON (director of onestly don't have have any	F	F 502  4. The Assistant Director of Nursing/Designee will review 20% of the residents scheduled for lab tests weekly for six weeks to ensure that have been obtained as ordered by physician and results are in the me record. If variances are identified, the physician will be notified. The Direct of Nursing will review findings and report any trends or variances to the CQI committee on at least a quarte basis.		
					RECEIV AUG 10 2 VDH/OL	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OMY111

Facility ID: VA0282

If continuation sheet Page 34 of 34

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